



KARNATAKA STATE OBSTETRICS AND GYNECOLOGY ASSOCIATION ETHICS AND MEDICOLEGAL COMMITTEE

MEDICOLEGAL BULLETIN

Week 23: Retained Surgical Sponge/Instrument After Cesarean or Gynecological Surgery – A Preventable "Never Event"

1. REAL LIFE CASE SCENARIO

A 32-year-old woman underwent emergency cesarean section for obstructed labour. The procedure was difficult, with adhesions and significant bleeding. Several weeks later, she presented with persistent abdominal pain, fever, and a discharging wound. Imaging revealed a retained surgical sponge in the abdomen. She required re-exploration and removal of the foreign body. Unlike many surgical complications where negligence depends upon whether reasonable care was exercised, a retained surgical item creates an exceptionally difficult medicolegal situation because it is considered largely preventable through proper counting and surgical safety systems.

The surgical team left something inside the patient — this allegation makes defense

2. MEDICOLEGAL RISKS IN SUCH CASES

Retained surgical items may include mops, sponges, gauze, instruments, needles, swabs, or other operative materials.

Risk increases during:

- Emergency cesarean sections
- Massive postpartum hemorrhage
- Obstetric hysterectomy
- Difficult laparotomy
- Multiple surgical teams
- Unexpected change in procedure
- Heavy blood loss
- Staff change during surgery

A retained surgical item creates a very difficult medicolegal situation because it is considered largely preventable.

3. WHAT THE LAW EXPECTS

The operating surgeon and OT team are expected to follow accepted surgical safety procedures:

- Standardized sponge and instrument counts
- Counts before surgery begins
- Counts before closure of a cavity
- Final count before completion
- Clear communication between surgeon and scrub team
- Investigation of every count discrepancy

A statement such as "the count was probably correct" provides little protection without supporting documentation. If the count is incorrect, closure should ordinarily pause until the discrepancy is resolved.

4. DOCUMENTATION – THE DOCTOR'S STRONGEST DEFENSE

- Initial sponge/instrument count.
- Names/designations of responsible OT personnel.
- Additional mops or instruments introduced.
- Steps taken to locate missing item.
- Final confirmation before completion.
- Scrub nurse verification noted.

- Final count before closure
- Any change in nursing/scrub personnel
- Any discrepancy detected
- Imaging performed if required
- WHO Surgical Safety Checklist completion
- Post-op findings if re-exploration required

A useful operative entry: "Sponge, needle and instrument counts confirmed correct with scrub nurse before abdominal closure."

Documentation should reflect what actually occurred — not be added routinely when the count was never performed.



MEDICOLEGAL BULLETIN

5. PRACTICAL SAFE PRACTICE – WHAT TO DO

- Use standardized OT counting protocols
- Never rely on memory alone — count aloud and systematically
- Document additional sponges introduced during surgery
- Repeat the count whenever personnel change
- Perform cavity inspection before closure
- Stop and reconcile any discrepancy before closing
- Use radiopaque surgical sponges wherever available
- Incorporate the WHO Surgical Safety Checklist

During PPH or chaotic emergency, assign someone specifically to maintain the count. Emergency makes safety systems more important, not less.

6. COMMON MISTAKES TO AVOID

- Assuming the scrub nurse alone is responsible
- Closing despite an unresolved count discrepancy
- Informal or undocumented counting
- Poor documentation during emergency surgery
- Failure to repeat count after staff change
- Using non-radiopaque mops where safer alternatives exist
- Altering operative notes after discovery of retained item

A retained surgical item is generally a team failure, but the operating surgeon cannot completely distance themselves from responsibility for operative safety.

7. CLINICAL–LEGAL PEARL

The safest retained-sponge litigation is the case that never happens.

Counting is not clerical work. It is a surgical safety procedure.

8. REAL COURT CASE INSIGHTS (FOR UNDERSTANDING)

Retained foreign-body cases are particularly difficult medicolegally because the occurrence itself may strongly suggest a failure of reasonable surgical precautions. Courts and consumer forums closely examine:

- Whether formal counts were performed
- Whether counts were documented
- Whether accepted OT protocols existed
- Whether a discrepancy was ignored
- Whether the postoperative complaint was investigated promptly
- Whether corrective treatment was provided without unnecessary delay

Simply describing a retained item as a “known surgical complication” is generally a weak defense.

The stronger approach is prevention through reliable systems.

9. TAKE-HOME MESSAGE

Retained surgical items are among the most preventable serious surgical events. The solution is not simply “Be more careful.” The solution is a system:

Count → Communicate → Recount → Resolve discrepancy → Document → Close.

Surgical skill saves the PATIENT.

A reliable OT system prevents the avoidable MISTAKE.

***Next Week's Topic; Abnormal Pap Smear / HPV Test Lost to Follow-Up
– Who Is Responsible When Cervical Cancer Is Diagnosed later?***



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